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Health
Lawrence + Memorial
Hospital

April 18, 2018

Heidi Caron, RN, MSN, BC, CLNC, SNC
Supervising Nurse Consultant
Facility Licensing and Investigations Sections
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

RE: Lawrence + Memorial Hospital Letter of Violation, April 12, 2018.

Dear Ms. Caron,

Please find enclosed Lawrence + Memorial Hospital's response to your letter of April 12, 2017 containing plans of correction and response for the violation set forth in the letter.

If you need additional information, please contact me at Marguerite.Langlais@YNHHS.org or by phone at 860-442-0711 Ext. 3402.

Sincerely,



Marguerite Langlais RN BSN, MS-PSL, CPHQ
Manager, Accreditation and Regulatory Affairs

ML:jd:enclosure

CC: Patrick Green
Denise Fiore
Oliver Mayorga, MD
Victoria Dahl Vickers

365 Montauk Avenue
New London, CT 06320
Phone: 860-442-0711 ext. 3402

lmhospital.org

FACILITY: Lawrence & Memorial Hospital
DATES OF VISIT: March 16 and 19, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6) and/or (j) Emergencies.

1. Based on clinical record review, facility documentation and interviews for one of three sampled patients (Patient # 1) known to be in the custody of the Department of Children and Families (DCF), the facility failed to protect a vulnerable patient when a high risk situation presented and/or failed to initiate the abduction response plan timely resulting in the patient being abducted by a non-custodial parent and an unauthorized person. The findings include:
 - a. Patient #1 (aged 3 years old) was admitted to the ED on 2/13/18 at 11:07PM. Patient #1 was accompanied by Person #1(non-custodial parent) and a female (Person #2). Person #1 alleged possible sexual abuse to Patient #1 by a family member who has custodial rights assigned by another state. It was determined that the child resides in the state of Connecticut with the family member with CT DCF involvement. Review of the clinical record notes dated 2/13/18 from 11:07PM to 11:54PM identified the patient had a history of fever in the last four hours, initial assessments were negative and a documented Temperature 102.9 F. Review of the ED notes dated 2/14/18 identified communication with DCF personnel and the local police department. The notes further identified DCF requested Patient #1 to remain at the hospital until their arrival at which point a safe place for discharge will be determined. Review of the clinical record note dated 2/14/18 at 1:23AM identified the sexual assault victim assessment identified normal appearance of vaginal and rectal area. Review of the ED notes dated 2/14/18 at 9:00AM identified RN#1 assumed charge of Patient #1 and RN#1 communicated with DCF to ascertain arrival time but no specific time was given. Review of the clinical record identified hourly rounding from 2/14/18 12:44AM to 2:30PM with Person#1 continuously updated on plan of care and informed that Patient #1 cannot leave until DCF arrives. Review of the ED notes dated 2/14/18 at 2:31PM identified Person#1 requesting to leave and indicating that he/she has daytime custody of Patient#1. Further review identified that the DCF caseworker was notified via voicemail message of Person#1's intention. On 2/14/18 at 3:12PM, Person #1 demanding to leave, MD#1 was notified by RN#1 of the situation. Review of the ED provider notes dated 2/14/18 by MD#1 identified RN#1 informed him/her that Person #1 had become agitated and requesting that Patient#1 be discharged. MD#1 went into Patient#1's room and noted that Person#1 became angry and yelling towards her. MD#1 could not locate Patient #1 in the room and inquired as to where he/she was. Person#1 refused to disclose the location of Patient#1.

Review of the video footage with the Public Safety Manager on 3/16/18 at 1:00PM identified the following staff interaction and activity with Patient#1 on 2/14/18 from 3:10PM to 3:23PM: 3:10PM Person#2 in hallway using cell phone near Patient#1's room, 3:12PM Person#2 is seen carrying Patient# 1 walking away from the nursing station towards a back exit leading into the waiting room area. At 3:14pm, Person#2 is seen carrying Patient#1, walks past the assigned public safety officer, exits the ED via the main entrance

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and is seen making a right turn towards the parking garage. At 3:18PM, MD#1 leaves Patient#1's room and walks towards the nurses' station. Person #1 leaves Patient#1's room walking away from the nursing station towards a back exit leading into the waiting room area and at 3:19PM Person#1 is seen walking through the waiting room. At 3:20PM, two public safety officers are conversing near the ED main entrance. Person 41 walks past the officers and exits the ED walking towards the street.

At 3:21PM, RN#1 is seen talking to the public safety officer assigned by the main entrance. At 3:21PM, MD#1, public safety officer and RN#1 exit the ED via the main entrance and at 3:22PM, MINI, public safety officer and RN#1 return into the ED.

Review of the facility Adverse Event investigation identified the internal code amber alert was initiated at 3:24PM by RN#1; 5 minutes after Person#1 was identified to have left the room.

Review of the clinical record dated 2/16/18 identified Patient #1 returned to the ED at 11:45PM by the local police for medical examination. Review of facility documentation identified the examination results were negative and the patient was discharged on 2/17/18 into the custody of DCF personnel.

Interview with the Public Safety Manager on 3/16/18 at 1:00PM, identified that a public safety officer is positioned outside the ED at the main entrance and another officer is positioned inside the ED for the crisis unit area at all times in addition to the officers being replaced every hour.

Interview with RN #1 on 3/19/18 at 11:05AM identified when he/she assumed charge of Patient#1 and was aware of Person#1's custodial status and that Person#1 was calm and co-operative when he/she interacted with him/her. RN#1 stated that he/she informed MD#1 that Person#1 was becoming frustrated and appeared agitated because of the delayed arrival of DCF personnel. RN#1 further identified that he/she did not inform a public safety officer of Person#1's changed behavior and did not believe Person#1 was a flight risk.

Interview with MD#1 on 3/19/18 at 11:50AM identified that RN#1 continuously updated his/her on the status of Patient#1 and initially there were no concerns with Person41. MD#1 identified RN#1 informed his/her that Person#1 was becoming agitated and as he/she entered Patient#1's room to introduce herself to Person#1 'stepped up to me'. MD#1 further identified Patient #1 was not in the room and upon inquiry and Person#1 declined to tell him/her where the patient was. MD#1 stated that he/she told Person#1 to remain in the room, went to the nurses' station, directed the secretary to call security and initiate the amber alert and also notified the public safety officer who was in close proximity. Upon return to the room, MD#1 stated Person#1 was not present.

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Interview with the Interim Director of the ED on 3/19/18 at 1:50PM identified when a patient who has been identified as a DCF client and is in a hold status the expectation is to expedite a plan of care to ensure safe and appropriate disposition. This would include optimal placement in the department, away from any exits and utilizing a sitter and/or observation guidelines. The interim Director of ED further identified in a high risk situation e.g. a person's behavior is escalating the primary nurse and MD should inform the charge nurse immediately to initiate awareness of a potential situation.

Review of the facility abuse identification and reporting policy identified in part that any physician examining a child suspected of being abused may keep the child in the custody of the hospital for no longer than 96 hours.

Review of the code amber abduction response plan identified in part that the purpose is to provide a rapid, organized and thorough response to suspected or actual infant/child abduction.

On 2/15/18, an immediate action plan regarding internal amber alert, pediatric patients on 96 hour hold and high risk patients in the ED was developed and implemented by the hospital. The plan identified all staff and personnel involved with the ED were educated, revision of policies, development of a pediatric patients on 96 hour hold algorithm, implement high risk patient log communication for security and code amber drills to be conducted and completed by 3/26/18.

DPH Citation	1. Measure(s) to Prevent Recurrence	Start Date	Completion Date
# 1a	• Immediate education was implemented in the Emergency Department (ED) inclusive of: nursing staff, unit clerks, public safety officers, technicians, medical staff providers, volunteer greeters, registration staff, and phlebotomy and radiology technicians.	2/16/2018	2/28/2018
	○ Education included review and signed acknowledgment of the following hospital policies: Abuse Identification and Reporting; Child Elderly/Mentally Retarded/Domestic Violence/Sexually Assaulted; Department of Children and Family Services; Code Amber Infant/Child Abduction Response Plan; Code Amber Unit Quick Reference Response	2/16/2018	2/28/2018

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	<p>Checklist.</p> <ul style="list-style-type: none"> To enhance team awareness of high risk situations, the ED Public Safety Officers immediately began to attend safety huddles in the ED. The ED Director developed an algorithm that guides the identification of pediatric patients in the ED that require a 96-hour hold. ED staff and support staff have been educated regarding the critical initial steps of a Code Amber/Infant and Child Abduction Response. Three Code Amber drills were conducted where the point of abduction is the ED. 	<p>2/15/2018</p> <p>2/16/2018</p> <p>2/15/2018</p> <p>3/15/2018</p>	<p>2/22/2018</p> <p>3/1/2018</p> <p>3/1/2018</p> <p>3/29/2018</p>	✓
	2. Monitoring Plans			
	<ul style="list-style-type: none"> ED staff have submitted a signed attestation form of the above targeted policies on Identification of abuse, Code Amber Response plan, and a quick response plan reference were reviewed and understood. Submission of Public Safety memorandum outlining potential ED risk situations and the Public Safety notification and hand off process. Submission of the Pediatric Patient/96 hour hold Algorithm and signed attestation from staff of the above targeted areas that the response plan was reviewed and understood. Completion of three Code Amber drills on three separate days and shifts with debrief and lessons learned review. 	<p>2/16/2018</p> <p>2/22/2018</p> <p>2/16/18</p> <p>3/19/2018</p>	<p>2/28/2018</p> <p>2/22/2018</p> <p>3/1/2018</p> <p>3/26/2018</p>	✓
	3. Staff Member by Title Designated for Monitoring the CAP			
	The Emergency Department Director at Lawrence + Memorial Hospital was designated to oversee the monitoring of these corrective action plans.			